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Ms. Julie Hamos, Director
State of Illinois
Department of Healthcare and Family Services

Mr. Michael McRaith, Director
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Dear Directors Hamos and McRaith:

Public Consulting Group (PCG) is pleased to present our comments in response to the Request for Public Comments by the Health Care Reform Implementation Council. These comments address the questions presented in the document released November 15, 2010, "American Health Benefits Exchange ("Exchange") in Illinois".

On July 30, 2010, Governor Quinn issued Executive Order 10-12 which created the Illinois Health Reform Implementation Council. One of the duties of the Council was to develop recommendations related to the establishment of a Health Insurance Exchange under the Affordable Care Act.

The Council has asked for public comments on the option of establishing an insurance Exchange in Illinois. PCG is pleased to present its comments. PCG has responded to many of the questions included in the Council's request. We would be pleased to meet with you to discuss our comments in more detail.

I. Functions of a Health Benefit Exchange

1. What advantages will Illinois see in operating its own exchange versus permitting the U.S. Department of Health and Human Services (HHS) to run an Exchange for the State?

The first of a series of threshold questions is whether Illinois should establish its own Exchange or cede this power to the federal government. The chief benefit of federal administration of an Exchange is for hard-pressed states, like Illinois, to escape the costs and logistics of building and supporting the ongoing operations of an Exchange. With grim fiscal forecasts of multi-billion dollar shortfalls, deferring to the federal government to operate the Exchange is not without appeal.

The Center on Budget and Policy Priorities estimates the budget deficit in Illinois at $13.5 billion in FY 2011 and $17 billion in FY 2012 so avoiding the costs of building and operating the Exchange may be an option.

However, with regard to financing the Exchange, the federal government has committed to fully funding the planning, design and initial implementation of state-based Exchanges through CY 2014. While the $1 million per state Exchange planning grants awarded in September 2010 did not factor in the varying levels of need across different states, federal officials have made it clear that the second round of grants, due to be announced in early 2011, will be needs based, and reflect the fact that establishing an Exchange in Illinois may require more significant costs and resources than establishing an Exchange in smaller states or states with different population patterns.

While a federal Exchange would ostensibly free Illinois from any financial and personnel/resource-related obligations, it would come with a cost. A federal Exchange, the details of which have not yet been developed, would present Illinois with a long list of practical difficulties, including, but not limited to, the following:

- Subjecting commercial insurers to federal regulatory authority (the Exchange) and state regulatory authority (the non-Exchange market);
- Exacerbating risk selection that could result from different rating and underwriting rules that might apply to policies sold inside versus outside of the Exchange;
- Foregoing coordination of benefits and eligibility rules across health coverage programs (e.g., Medicaid, CHIP and the Exchange); and
- Greatly compromising the State's ability to promote broader health reform strategies and priorities through the Exchange, the State's Medicaid program, and the public employees' health benefits plan.

Without a doubt, establishing an Illinois-administered Exchange carries risks and rewards. An Exchange that efficiently and effectively connects people with health insurance can be a powerful force for change in the State. This would address many of the goals presented by the Council for Health Care Reform, including improvement of enrollment systems and testing of new payment systems. This will take time and effort,

with plenty of challenges along the way. Illinois officials, as well as health insurers, consumers, advocates, employers, providers, brokers, and other stakeholders, are rightfully concerned about how this new entity will fit into the existing markets.

Allowing the federal government to operate the Exchange is clearly an option for Illinois to consider. But, in making that decision, the State must carefully weigh the advantages and disadvantages. Illinois has a unique opportunity to create an Exchange that works for Illinois businesses and residents. PCG believes the advantages of Illinois establishing a State-administered Exchange greatly outweigh the potential disadvantages.

2. What are the most desirable outcomes from an insurance market perspective? What features should the Exchange contain in order to reach those outcomes?

The most desirable outcomes for an Illinois Exchange should reflect the goals, objectives, values and benefits expressed by the broad range of stakeholders the State has already engaged, and will continue to engage, in this important initial planning process, as well as throughout the design and implementation stages for the Exchange.

In addition, PCG suggests the following:

- Shift the market from one based on risk avoidance to one based on price and quality by establishing an Exchange that rewards health carriers and providers based on cost, quality and efficiency in the administration of insurance and the delivery of care;
- Promote cost-efficient and high quality care by structuring the selection criteria for qualified health plans to reflect high performance networks, where appropriate and available;
- Protect consumers throughout the market, both inside and outside the Exchange, by enforcing market conduct rules and holding all insurers accountable for fairly and accurately processing administering benefits;
- Encourage market competition through the development of an open, transparent and fair selection process for qualified health plans;
- Engage consumers in their own health and encourage residents to take greater ownership of their health care decisions by promoting qualified health plans that reward and incentivize people for prevention and wellness;
- Reach the chronically uninsured, filling the gaps for the acute uninsured, and minimizing churn across public and private insurance by establishing an administratively simple, streamlined, and seamless eligibility and enrollment process, and through the development of a robust and comprehensive outreach, education and enrollment program;

- Lower the cliffs and reduce the differences between public and private coverage by establishing a sliding scale of benefits and costs across Medicaid, the Exchange, the unsubsidized individual market, and employer-sponsored insurance; and
- Eliminate underinsurance by establishing baseline standards for comprehensive health insurance.

3. What, if any, Exchange functions beyond the minimum clearinghouse functions required in the ACA would benefit Illinois and why?

Illinois should consider establishing an Exchange that acts as a selective contracting agent, rewarding qualified health plans that offer comprehensive coverage at the greatest value to consumers. This more aggressive approach to contracting and selecting insurers will need to be balanced against the need for the Exchange to offer consumers a range of health plans and health insurers from which to choose. In some respects, the Exchange may be able to achieve the goal of promoting high-quality/lower-cost health plans by providing a platform that allows consumers to fairly compare products among competing insurers.

It should provide consumers with decision support tools that enable them, many of whom will be purchasing commercial insurance on their own for the first time, to make informed choices about which health plan will best meet their needs. The development of user-friendly tools that help guide an individual through this process will be an important function that goes beyond the minimum clearinghouse requirements of the ACA.

The State should also consider coordinating the activities of the Exchange with the State's Medicaid program and the State's public employees' health benefits plans. How best to leverage and use this market power will be an important and delicate balancing act for Illinois, but the State should not miss the opportunity to bolster and support large health reform initiatives through these three points of contact with insurers.

4. What advantages are presented to Illinois if the Exchange were to limit the number of plans offered; for example, plans could be required to compete on attributes such as price or quality rating? Is the Exchange a stronger marketplace if it permits "any willing provider" to sell coverage?

Illinois has the opportunity to leverage the Exchange's market power to further enhance competition among insurers based on price and quality. To do this, the Exchange may attempt to exert its influence in the market and enhance competition by contracting with a limited number of carriers offering a select group of health plans, or by requiring

that health carriers and health plans meet certain cost and/or quality metrics. The Exchange might also solicit plans based on preferred plan designs or features, or, depending on the number of carriers operating in the state, the Exchange might decide to offer only the four or five lowest-priced carriers, for example.

Given the Exchange's role in the market and the availability of premium subsidies for low and moderate income individuals, carriers offered through the Exchange will likely have exclusive access to a sizeable population. This heightens the responsibility of the Exchange to establish a fair and open health carrier and health plan selection process, regardless of the decision to be a selective contracting agent or to permit "any willing provider."

A balance must be struck between being overly aggressive in the selection of "qualified health plans" and the reality of a marketplace that will be going through major changes in the manner by which health insurance is priced and sold. If the Illinois Exchange is too aggressive and out of pace with the rest of the market, it runs the risk of not attracting enough carriers, offering too few health plans, and/or offering products that are not commercially viable.

Product development takes time, and the Exchange should recognize this reality and consider a multi-year plan if it wishes to move the market and/or promote certain types of health plans. Understanding the current market, developing a strategic plan to promote broader health insurance reform, and coordinating these efforts with other public health coverage programs (e.g., Medicaid, state employees' health benefits program) will be crucial to the ultimate success of the Exchange.

II. Structure and Governance

1. If Illinois chooses to establish its own Exchange, which governance structure would best accomplish the goal of more affordable, accessible health insurance coverage? Why?

The challenge for policymakers is in crafting infrastructure, governance and accountability standards so that an Illinois Exchange – wherever it may be housed and however it may be governed – is nimble and capable of developing a major new program and modifying that program as circumstances change. The Exchange will need to respond to changing market conditions, evolving preferences of consumers, and ongoing development and issuance of federal regulations and guidelines regarding the administration and operation of the Exchange. Accommodating the mission and practical operating considerations of an Exchange requires close attention to a number of issues:

- What financing mechanism will best support the need for an Exchange to hit the ground running in order to meet the ambitious timelines contained in the ACA?
- What is the corporate form that best accommodates an entity with governmental purposes, but also the need to establish a business plan for a technologically-dependent new product, market it, and win over consumers, businesses and health plans so that it is able to grow and support its expenditures?
- Given the voluminous duties the Exchange faces and tight time constraints, what is the structure that promotes informed and transparent public input, prompt decision making, the ability to execute decisions expeditiously, and to pivot quickly in the face of shifting market conditions, and an evolving regulatory environment?
- With the likelihood that the Exchange will tap the strengths of existing regulatory agencies in assuming its responsibilities, what structure ensures close coordination and efficient allocation of resources between the Exchange and State agencies?
- Since the end users of Exchange services—individuals and small businesses—will likely support the Exchange's operations through the premium payments they make, and the Exchange will in effect compete against existing distribution systems in the non-Exchange markets, what is the most cost-effective method to administer the Exchange and provide for ongoing operations?
- The Exchange will need to establish rules and it will have to do so in a fast-moving environment. How can the Exchange be organized so that it can establish rules in response to changes in the market and legislative environments?
- Finally, what structure best enables Illinois and its new Exchange to navigate the many uncertainties that lie ahead?

Uncertainty, in fact, may be the one certainty in the environment in which Exchanges are to be implemented, and it derives from three sources:

- Ongoing federal litigation seeking to have key portions of the ACA declared unconstitutional;
- The pledge by a new Republican majority in the House of Representatives to "repeal and replace" the ACA and block funding for ACA-related activities; and
- The significant discretion granted to HHS and the states on fundamental and interconnected policy questions that will impact the Exchange's operations.

On the federal side, uncertainties include second round funding for Exchange implementation grants, support for state IT needs, rules for how exactly small employer

groups will purchase coverage from the Exchange, a system for rating health plans, guidelines for Co-op and multi-state plans which could join existing state health plans in offering coverage through the Exchange, regulations establishing "minimum essential benefits," designation of open enrollment periods, and guidance on three separate and complex risk mitigation mechanisms.

On the state side, policymakers and regulators will grapple with whether to merge the individual and small group markets, choose 50 employees or 100 as the limit for small group coverage, opt to return Exchange subsidies for individual earning between 133 and 200 percent of the FPL and instead provide coverage through a Basic Health Program, how to establish rating areas for all plans, and the degree to which the non-Exchange market should be linked to the Exchange market in order to protect both markets against adverse selection. Finally, decisions on how best to implement the required coordination of Exchange functions with Medicaid and CHIP eligibility and enrollment determinations looms large.

The broad range of tasks under the Exchange's purview does not lend itself to a familiar organizational structure, either public or private. On the one hand, the Exchange has governmental responsibilities, such as determining eligibility for publicly-subsidized coverage, verifying citizenship of enrollees, certifying exemptions under the individual mandate, and exchanging information with the federal government. On other hand, the Exchange will need to operate like a private enterprise, serving as a distribution channel for commercial health insurance, working with small employers – and potentially with large employers – to provide their employees with commercial coverage, generating revenues to support operations, and competing against existing distribution channels for customers.

An Exchange likely lends itself more to a public/private hybrid model that can balance the regulatory aspects of its governmental responsibilities with its commercial operations. If financed through fees charged to participating health plans, the Exchange will need to compete for business by attracting and retaining customers in order to become financially viable and self-sustaining, Achieving the proper balance between public accountability and transparency with the need to be agile and responsive to consumer demands will require an entity that is subject to government oversight but provides significant flexibility to achieve its commercial objectives.

2. If the Exchange is run by an executive director and/or a governing board, what should be the expertise of those appointed? How long should the terms be? Are there existing models to which the State should look?

As opposed to an agency, with its built-in accountability standards and management structure, the creation of a public authority means policymakers will have to devote considerable attention to determining how it is governed. Policymakers must determine the size of the board, and how members are appointed. These decisions include whether: the Governor is authorized to appoint a majority of voting members; key agency heads serve as ex-officio members; both voting and non-voting members are empanelled; members are appointed based on their expertise in particular areas, or as representatives of important interests, such as consumers, labor, business; and if a regional balance should be reflected in the board.

The size of the board is a key consideration, particularly given the Exchange's need to act quickly in response to market conditions or federal guidance. As important as the size of the board and the method of appointment, the qualifications of members are of equal import. The chart below illustrates the decisions Massachusetts and California made in legislation creating an Exchange board.

	Massachusetts	**California**
Board Composition	11 members • 4 ex officio • 7 private members	5 members • 1 ex officio • 4 others, may be public or private
Length of service	3 years	4 years
Board members' qualifications	Four ex officio members • Secretary of Administration and Finance (chair) • Medicaid Director • Exec. Dir. of Group Insurance Commission (state employees and retirees health plan) • Commissioner of Division of Insurance Seven Private members • Actuary • Health economist • Small business representative	One ex officio member • Secretary of Health and Human Services Four other members, with expertise in a least two of the following areas: • Individual market • Small group market • Health benefits administration • Health care finance • Administering a public or private health care delivery system • Purchasing health plan coverage

	Massachusetts	California
	• Employee health plan specialist • Health consumer organization representative • Representative from organized labor • Health insurance broker[1]	
Location within state government	Public authority, not under direct control of a state agency	Public authority, not under direct control of a state agency

Because board composition and qualifications will be of critical importance to the success of an Exchange, policymakers face a number of key decision points. A board that is too large may prove unwieldy and incapable of acting nimbly. A board structured under interest group membership may lose focus on the success of the enterprise as a whole. A board without individuals with specific expertise may lack the know-how to develop and execute a business plan. Threading the needle on board composition will also mean developing an understanding of the Exchange's relationship to the Executive branch. Unless the Exchange is envisioned as a "third regulator" with in-house capacity to regulate qualifying health plans, for example, the new entity will need close coordination with the Department of Insurance and the Department of Healthcare and Family Services, since it may delegate or even contract with these agencies to perform various functions.

In Massachusetts, the Connector has relied heavily on a number of state agencies in implementing and operating health reform. The State's Medicaid agency, MassHealth, serves as a crucial partner in the subsidized insurance program, Commonwealth Care. MassHealth determines eligibility for almost all medical assistance programs, including Commonwealth Care, and the Connector utilizes an interagency services agreement to pay MassHealth for its work in processing eligibility, notifying members of program changes, and conducting the redetermination process, among other functions. In addition, MassHealth serves as the conduit through which the Connector obtains medical claims data on Commonwealth Care members, which the Connector uses for a number of purposes, including risk adjusting payments to Commonwealth Care MCOs.

[1] Legislation passed in June 2010 added a broker representative to the Massachusetts Connector board, effective July 2011.

With regard to the commercial insurance program, Commonwealth Choice, the Connector works closely with the Massachusetts Division of Insurance (DOI) to ensure the consistent application of rating rules and other commercial insurance regulations. The DOI and the Connector also collaborated on the development of regulations for the Young Adult Plans, which are offered solely through the Connector and allow for less comprehensive coverage than the minimum standards that apply to all other health plans. In addition, the Connector has relied on the DOI to interpret regulations pertaining to the commercial market on a number of occasions when there arose a disagreement between the Connector staff and the carriers. Having the State's Commissioner of Insurance on the board of the Connector was extremely important in both ensuring that the Connector abided by the state's insurance rules and regulations, as well as maintaining the active and willing participation of the insurance carriers.

Finally, a key question relates to the whether the board will have a policy-making role, in effect legislating on particular discretionary issues. While it may be less applicable to an Illinois Exchange under federal health care reform, key policy decisions made by the Connector included the minimum level of insurance coverage necessary to satisfy the individual mandate, affordability and hardship criteria pertaining to exemptions under the individual mandate, as well as the levels of subsidies available to lower-income individuals. All of these decisions were made by the Connector. Under federal reform, they are either set in statute or are the purview of the Secretary of Health and Human Services, and many of the remaining larger issues facing the Exchange will require state legislation to be put in place. Still, issues such as whether to combine the individual and SHOP Exchanges and the criteria for selecting "qualified health plans," for example, may well be left to the Exchange, requiring careful consideration of its governance structure, both as a delegation of power that the Governor and the Legislature may wish to retain, but also as an opportunity to isolate certain decision making functions from political exigencies.

III. The External Market and Addressing Adverse Selection

1. Should Illinois establish a dual market for health insurance coverage or should it eliminate the external individual market and require that all individual insurance be sold through the Exchange? What would be the effects of doing so?

Given the significant challenges that Illinois faces in establishing an Exchange and implementing health reform, any decision to eliminate the external individual market should be carefully considered. On the one hand, consolidating the individual market through the Exchange could improve administrative efficiencies if the Exchange can establish cost-efficient processes for enrolling and administering health insurance. On

the other, requiring all individual policies to be purchased through the Exchange could cause significant market disruption for the tens of thousands of people currently purchasing coverage in this market.

A second consideration involves the types of plans that will be available through the Exchange. Because the Exchange is allowed, under the ACA, to only offer qualified health plans in five levels or tiers based on actuarial value (i.e., Platinum, Gold, Silver, Bronze and Catastrophic), individuals who are enrolled in plans that fall outside of these pre-determined values might be forced to switch coverage or drop insurance. In addition, the Exchange is prohibited from enrolling people who are not legal citizens or legal aliens. Eliminating an alternative market would effectively remove the ability of people who are not legally in the state from purchasing health insurance.

Also, there will be residents who are unable to afford health insurance, have income that exceeds the premium-subsidy level, and are exempt from the insurance mandate (e.g., older individuals with income above 400% FPL who do not have access to employer-subsidized insurance). An individual market outside the Exchange might offer these individuals a very high deductible health plan with deductibles that exceed the "catastrophic" coverage level offered through the Exchange. Such a policy would provide these residents with a modicum of protection against the expenses of a major illness or accident. Eliminating the external market would effectively prohibit these individuals from any protection against health care related bankruptcy.

2. What other mechanisms to mitigate "adverse selection" (i.e. requiring the same rules for plans sold inside and outside of the Exchange) should the state consider implementing as part of an Exchange?

The application of the same rating rules inside and outside the Exchange is a critical requirement to protect against adverse selection that may occur in one or the other market (i.e., inside the Exchange or outside the Exchange). The experience of California's health insurance purchasing cooperative, Pac Advantage, demonstrates the painful lesson of different rating rules within a market. By applying different rating rules, Pac Advantage wound up enrolling people with greater medical needs than those purchasing coverage through the existing market. And, because the rating pools were segregated – which won't be the case with the Exchange – the cost of coverage through Pac Advantage became more expensive and a "death spiral" ensued. As a result, at the end of 2006, Pac Advantage closed its doors.

In addition to the same rating rules inside and outside the Exchange, the underwriting rules that carriers apply to small groups must be the same across these markets. For example, if small employers purchasing coverage through the Exchange must meet

participation requirements (i.e., percentage of employees that are covered by the policy) that differ from the participation requirements for small employers purchasing coverage outside the Exchange, carriers operating inside the Exchange may be advantaged or disadvantaged. In addition, the Exchange itself may be advantaged or disadvantaged, vis-à-vis other distribution channels (i.e., policies purchased through brokers or direct from the carriers), if the rating and underwriting rules are not consistently applied.

In addition to these regulatory and sub-regulatory methods to address risk selection, aggressive outreach and marketing efforts will be necessary to attract a broad and diverse risk pool. Even with the availability of heavily-subsidized premiums and reduced cost sharing, the Exchange runs the risk of enrolling a disproportionate share of older and/or sicker individuals. The experience of state Medicaid programs is also worth noting. Despite the availability of free health coverage, tens of thousands of eligible individuals are either unaware of their eligibility or choose not to enroll. An aggressive and sustained outreach and enrollment effort will be necessary to attract a large and diverse risk pool necessary to sustain the Exchange and to protect the carriers offered through the Exchange. The Exchange can involve many agencies in this effort. For example, information provided by the Department of Revenue about the State's Earned Income Tax Credit could also publicize access to the Exchange.

3. Are there hybrid models for the Exchange the State should consider? What characteristics do they offer that would benefit Illinoisans?

4. If the Exchange and the external market operate in parallel, what strategies and public policies should Illinois pursue to ensure the healthy operation of each? Should the same rules apply to plans sold inside and outside an Exchange? Should the same plans be sold inside and outside the Exchange without exception?

See above regarding the application of the same rules inside and outside of the Exchange.

However, while the same rules inside and outside of the Exchange are important, Illinois should consider allowing the Exchange to provide small employers with a defined contribution option that would allow employers to contribute a fixed dollar amount for their employees' coverage that is lower than the minimum amount/percentage typically required by insurers. Employees under this type of arrangement might be treated as individual purchasers for the purpose of rating and pooling purposes, but would allow employers to contribute to the purchase of health insurance by employees who might otherwise not be able to afford coverage.

This type of financing arrangement might enable employers that are currently unable to provide health insurance to their employees because they cannot afford insurers' minimum contribution requirements to offer some financial assistance to their employees' purchase.

In addition, we suggest that the same plans should be sold inside and outside the Exchange, and that the Exchange must be cognizant of, and responsive to, the outside market. Setting plan selection criteria too high or requiring certain rules inside the Exchange that are out of step with the rest of the market can lead to the Exchange failing to attract sufficient volume to achieve administrative efficiencies.

5. What rules (if any) should the State consider as part of establishing the open enrollment period?

It is critical that the Exchange, and in fact the entire individual market, enforce enrollment periods fairly and consistently. A significant problem in the Massachusetts market occurred as a result of continuous open enrollment in a guaranteed issue market. Some individuals were purchasing coverage in this market, undergoing expensive medical care/procedures, and then dropping coverage. The effect on insurers from this adverse selection is discussed in a report (http://www.mass.gov/Eoca/docs/doi/Companies/adverse_selection_report.pdf) issued by the Massachusetts Division of Insurance in June 2010. Based in part on this analysis, the Massachusetts Legislature eliminated continuous open enrollment for individual coverage and established two discrete periods during which people can purchase individual coverage.

However, off-cycle enrollment will be necessary in order to provide people who experience a change in circumstances with the ability to purchase health insurance. This may occur, for example, when people change jobs, move into the state, move from across the state and outside the region of their insurer, as well as a host of other circumstances. The State will need to establish strict standards by which people will be allowed to purchase coverage outside of the open enrollment period. These standards will need to be applied equally across the market, inside and outside the Exchange.

In addition to strictly enforcing open enrollment periods, the State might also consider allowing carriers to apply waiting periods for electoral procedures and certain other services.

6. The ACA requires states to adopt systems of risk adjustment and reinsurance for the first three years of Exchange operation. How should these tasks be approached in Illinois? What are issues the State should be aware of in establishing these mechanisms?

7. Given the new rules associated with the Exchange, and the options available for restructuring the current health insurance marketplace, what should the state consider as it relates to the role of agents and brokers?

In light of the possible exclusion of health insurance brokers from serving as Navigators due to the prohibition against Navigators receiving direct or indirect compensation from carriers for the enrollment of individuals in health plans, the Exchange will need to determine how best to use brokers to facilitate enrollment and assist consumers. Although health insurance brokers' level of involvement in the individual and small group markets varies, they play an influential and important role in the distribution of health insurance in Illinois.

For many small businesses, brokers serve as the de facto benefits offices, providing firms with a range of services including assistance with health insurance, disability coverage, life insurance, and other ancillary lines of coverage. Business owners rely on brokers to sort through their health insurance options, provide health plan recommendations at the time of renewal, and serve as their agents throughout the year in dealings with insurers.

In determining the role that brokers may play in the operation of the Exchange, a number of key issues/questions are worth considering:

- What is the current role of brokers in the individual and small group markets?
- What types of services do brokers provide for their clients, beyond the annual health plan selection process?
- How are brokers compensated? Do brokers receive a percentage of the monthly premium, or a flat dollar amount, unrelated to the monthly premium?
- Do brokers receive additional compensation – sometimes referred to as retention bonuses or overrides – for meeting targets for renewing business with a carrier?
- How might those payments factor into any Exchange-based payment model for brokers?
- Should brokers fees be transparent and paid separate and apart from the premium?

The Exchange will likely want to coordinate the manner by which brokers are compensated and any change in disclosure requirements with the rest of the commercial market to ensure a level playing field across the various distribution channels.

How to utilize brokers and determine how they fit into the Illinois Exchange's outreach and enrollment program is one of the more important decisions to be made by the State. Brokers typically have longstanding and trusting relationships with their clients and provide information at the ground level about health insurance options. Determining how best to leverage the expertise of health insurance brokers and to make an effort to include them in the outreach and enrollment program may prove invaluable to the ultimate success of the Illinois Exchange.

IV. Structure of the Exchange Marketplace

1. Should Illinois operate one exchange or two separate exchanges for the individual and small group markets? Why?

2. If there will be separate markets and separate exchanges, how large must the pools within these markets be to ensure stable premiums for both?

3. What should the Illinois definition of small employer be for initial Exchange participation in 2014?

4. Should Illinois consider setting any conditions for employer participation in the shop Exchange (e.g. minimum percent of employees participating, minimum employer contribution)?

5. Should Illinois permit large group employers with more than 100 employees to participate in the Exchange beginning in 2016? Are there any special considerations for including this group of which the State should be aware?

6. Should Illinois consider creation of separate, regional exchanges for different parts of the State? Should Illinois consider a multi-state Exchange?

The decision regarding multi-state, statewide or regional (i.e., subsidiary) Exchanges is another threshold issue for all other Exchange-related work that the State will undertake. With the approval of the HHS Secretary, and the permission of each state, an Exchange may operate in more than one state. This option may be of limited attractiveness to Illinois and its neighbors, with regards to higher population density, active insurance markets, and complex political institutions.

In general, the appeal of a multi-state Exchange lies in the potential for increased efficiencies that may be gained by combining the Exchange functions and services, and in establishing an enrollment base large enough to sustain the Exchange operations on an ongoing basis. North and South Dakota, with a combined population of 1.5 million might be more likely candidates to establish a multi-state Exchange than Illinois and Indiana, with a combined population of 19.3 million, or Illinois and Wisconsin, with a combined population of 18.6 million.

Even with the leveling effect of the ACA on state rating and underwriting rules, there will remain a number of differences among Illinois and its neighbors with regard to state mandated health benefits, insurance regulation, and risk mitigation mechanisms (e.g., risk adjustment, reinsurance, and risk sharing). Finally, the numbers of consumers likely to access an Illinois Exchange greatly minimizes any additional administrative efficiency that could be achieved by joining another state, or states, in establishing a multi-state Exchange.

With regard to regional or subsidiary Exchanges, any benefits from heightened sensitivity to local market conditions (e.g., greater Chicago or southern Illinois) would need to be weighed against the increased difficulty of implementing and financing such a system, duplicating Exchange functions, and complicating relations between the subsidiary Exchanges and state regulators at DOI and DHHS. Furthermore, would these subsidiary Exchanges have their own boards; would each Exchange need to establish its own eligibility and enrollment systems; develop their own criteria for selecting "qualified health plans"; and create their own reporting requirements for qualified health plans?

An alternative way to approach the question of subsidiary vs. statewide Exchanges is to consider whether there can be strong regional components within a statewide Exchange. A statewide Exchange could organize regional service networks to serve customers' needs, including regional Navigator programs, regional offices or walk-in centers where Illinoisans could go for in-person assistance, and regionally-oriented brokers and agents who could provide a deeper level of service to prospective customers.

V. Self-Sustaining Financing for the Exchange

1. How should the Exchange's operations be financed, after federal financial support ends on December 31, 2014?

2. What are the ramifications of different financing options, specifically as they relate to the unique characteristics of Illinois' existing economy and health insurance marketplace?

3. Should the State consider a separate funding source for maintaining state benefit mandates? If so, what are some options?

VI. Eligibility Determination

1. How should the Exchange coordinate operations and create a seamless system for eligibility, verification and enrollment in the Exchange, Medicaid, the Children's Health Insurance Plan (CHIP), and perhaps other public benefits (food stamps, TANF, etc.)?

2. When enrollees move between public and private coverage, how should Illinois maintain continuity of health care -- in plan coverage and in availability of providers, e.g. primary care physician?

3. What will maximize coordination between Medicaid, as a public payer, and insurance companies, as private payers, offering health insurance on the Exchange in their provider networks, primary care physicians ("medical homes"), quality standards and other items?

4. Should Illinois establish a "Basic Health Plan"? If so, what should be included in such a plan? Specifically, what does a "basic health plan" offer as a tool to facilitate continuity of coverage and care?

Illinois will need to consider not only whether it may be able to offer individuals with income between 133 percent and 200 percent FPL a richer health benefit package for less, but also the potential impact to the commercial insurance market that may result from separating those individuals from the rest of the risk pool. Individuals eligible for the Basic Health Program will not be eligible for premium subsidies and reduced cost sharing through the Exchange.

It is likely that individuals with income between 133 percent and 200 percent FPL will constitute a sizeable proportion of the uninsured that will be eligible for premium subsidies for commercial insurance through the Exchange. Roughly 25 to 30 percent of the uninsured in the State have income between 100 percent and 200 percent FPL. Removing that group of purchasers from Illinois' individual market and separating them from the Exchange may have a number of consequences, including:

- Negatively affecting premiums in the individual market by splitting off a large group of people – quite possibly younger and healthier than the broader uninsured population – who would otherwise enroll in coverage through the Illinois Exchange;
- Reducing the number of people covered through the Exchange, thereby making it less attractive for commercial insurers to participate;
- Limiting the Exchange's ability to promote other health reform priorities; and
- Affecting the ability of the Exchange to achieve economies of scale, thereby increasing the per-member administrative costs of the Exchange.

Perhaps the most significant factor that Illinois should consider before deciding to establish a Basic Health Program involves the reduced cost sharing and increased actuarial value of Silver level plans for individuals with income at or below 400 percent FPL. As shown below, this provision of the ACA will minimize the effective cost of coverage (i.e., premiums and point-of-service cost sharing) for lower-income individuals.

The ACA requires plans sold through the Exchange to limit out-of-pocket expenditures to the maximum allowed under the federal rules pertaining to high deductible health plans (HDHPs) that qualify individuals for health savings accounts (HSAs). The current out-of-pocket maximum for an HSA-qualified HDHP is $5,950 (individual) and $11,900 (family).

However, federal law provides cost-sharing subsidies that will further reduce the out-of-pocket expenses for individuals at or below 400 percent FPL. These cost-sharing subsidies will effectively increase the value of the Silver level plan, particularly for individuals with income at or below 200 percent FPL. The table below displays the subsidies that will be provided to individuals purchasing Silver level coverage through the Exchange.

These cost-sharing subsidies and increases in the actuarial valuation of Silver level plans for individuals with income at or below 200 percent FPL may address the concerns expressed by some with regard to the potential out-of-pocket costs for lower-income individuals who purchase coverage through the Exchange, and may obviate the need to establish a Basic Health Program for these individuals.

Income Category	Reduction in Out-of-Pocket Limit Relative to HAS/HDHP Maximum	Out-of-Pocket Limit (based on 2010 HAS/HDHP Maximum)	Actuarial Value of Silver Plan
Up to 150% FPL	Reduced by two-thirds	$1,963/$3,927	94%
150.1 – 200% FPL	Reduced by two-thirds	$1,963/$3,927	87%
200.1 – 250% FPL	Reduced by one-half	$2,975/$5,950	73%
250.1 – 300% FPL	Reduced by one-half	$2,975/$5,950	70%
300.1 – 400% FPL	Reduced by one-third	$3,986/$7,973	70%
Above 400% FPL	No reduction	$5,950/$11,900	70%

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PCG would be pleased to meet with State personnel involved in Exchange planning. Please feel free to contact me in PCG's Chicago office or Robert Carey in our Boston office. We can be reached as follows:

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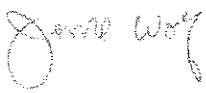
Sincerely,



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